What is Meaningful Use?

The American Recovery and Reinvestment Act (ARRA) stimulus package includes incentives for rural and Critical Access Hospitals (CAH) that attain meaningful use of their electronic health record (EHR) systems. To be an eligible hospital for Medicare and Medicaid incentives, facilities must use a certified EHR system in a meaningful manner, exchange health information to improve the quality of care (through a health information exchange, if available), and report on hospital clinical quality measures. To earn incentives and avoid penalties facilities should meet these requirements by 2015. Those who achieve meaningful use earlier will earn the largest amounts with incentives decreasing over time.

Meaningful use will be rolled out using a phased approach and will be updated over time. The final Stage 1 criteria have been released. Stages 2 and 3 are not fully defined but will expand on Stage 1, increasing what is required of the provider over time (see page 3).

Targeted Stages of Meaningful Use by Payment Year

First Payment Year	Payment Year				
	2011	2012	2013	2014	2015
2011	Stage 1	Stage 1	Stage 2	Stage 2	TBD
2012		Stage 1	Stage 1	Stage 2	TBD
2013			Stage 1	Stage 1	TBD
2014				Stage 1	TBD
2015					TBD

Stage 1: The Stage 1 meaningful use criteria focus on electronically capturing health information in a coded format; using that information to track key clinical conditions, and communicating that information for care coordination purposes in a structured format, whenever feasible.

Objectives and Measures: Objectives and Measures are divided into two sets, Core and Menu. Providers must meet all Core Set measures and must select and meet five (5) measures from the Menu Set. At least one public health measure must be selected.

Stage 1 Meaningful Use Criteria

OBJECTIVES/MEASURES – CORE SET

Priority Area #1 – Improve quality, safety, efficiency, and reduce health disparities

- ✓ **Computerized Provider Order Entry (CPOE) for medication orders:** Use CPOE for at least one medication order for more than 30% of patients admitted to the inpatient or emergency department with at least one medication in their medication list
- ✓ **Medication Interaction/Contraindication Checks:** Enable functionality in EHR for automated drug-drug and drug-allergy checks
- ✓ **Patient Problem List:** Maintain an up-to-date problem list of current and active diagnoses (at least one entry recorded as structured data) for more than 80% of all unique patients admitted to the inpatient or emergency department
- ✓ **Active Medication List:** Maintain an active medication list (at least one entry recorded as structured data) for more than 80% of all unique patients admitted to the inpatient or emergency department
- ✓ **Active Medication Allergy List:** Maintain an active medication allergy list (at least one entry

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OBJECTIVES/MEASURES – CORE SET

recorded as structured data) for more than 80% of all unique patients admitted to the inpatient or emergency department

- ✓ **Patient Demographics:** Record demographic data (including preferred language, gender, race and ethnicity coded by federal guidelines, date of birth, date and preliminary cause of death in the event of mortality) as structured data for more than 50% of all unique patients admitted to the inpatient or emergency department
- ✓ **Vital Signs:** Record and chart vital signs (including height, weight, blood pressure) for more than 50% of all unique patients 2 years of age or older admitted to the inpatient or emergency department
- ✓ **Smoking Status:** Record smoking status as structured data) for more than 50% of all unique patients 13 years old or older admitted to the inpatient or emergency department
- ✓ **Quality Measures Reporting:** Report hospital clinical quality measures[1] to CMS (for 2011, through attestation; for 2012, electronically)
- ✓ **Clinical Decision Support Rules:** Implement one clinical decision support rule relevant to specialty or high clinical priority

Priority Area #2 – Engage patients and their families in their healthcare

- ✓ **Electronic Copy of Patient Health Record:** More than 50% of all patients who request an electronic copy of their health information (including diagnostic test results, problem list, med list, med allergies) are provided it within 3 business days
- ✓ **Electronic Copy of Discharge Instructions:** More than 50% of all patients discharged from the inpatient or emergency department are provided with an electronic copy of their discharge instructions upon request

Priority Area #3 – Improve care coordination

- ✓ **Clinical Information Exchange:** At least one test of exchange key clinical information (for example, problem list, med list, med allergies, diagnostic test results), electronically among providers through a certified EHR

Priority Area #4 – Ensure adequate privacy and security protections for personal health information

- ✓ **Electronic Health Information Protection:** Ensure the protection of electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities; by conducting or reviewing a security risk analysis, implementing security updates as necessary, and correcting identified deficiencies

OBJECTIVES/MEASURES – MENU SET

Priority Area #1 – Improve quality, safety, efficiency, and reduce health disparities

- ✓ **Medication Formulary Checks:** Enable functionality in EHR for automated drug formulary checks with access to at least one internal or external drug formulary for the entire EHR reporting period
- ✓ **Lab Results:** Clinical lab tests results, in a positive/negative or numerical format, captured as structured data for more than 40% of all labs ordered
- ✓ **Patient Lists:** Generate at least one report listing patients with specific conditions for use in quality improvement, reduction of disparities, research, or outreach
- ✓ **Advanced Directives:** More than 50% of unique patients 65 years or older admitted to the inpatient

[1] Refer to Quality Measures document or visit http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf pages 44418-44419

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OBJECTIVES/MEASURES – MENU SET
department have an indication of advanced directive status recorded. ***Priority Area #2 – Engage patients and their families in their healthcare*** ✓ **Patient Education:** Use certified EHR technology to identify and provide patient-specific education resources to more than 10% of unique patients admitted to the inpatient or emergency department ***Priority Area #3 – Improve care coordination*** ✓ **Medication reconciliation:** Perform medication reconciliation for more than 50% of transitions of care for patients who are transitioned to the care of an eligible provider or admitted to the hospital's inpatient or emergency department ✓ **Summary of Care Record:** Provide a summary of care record for more than 50% of transitions of care and referrals ***Priority Area #4 – Improve population and public health**** ✓ **Immunization Registries:** At least one test of submission of electronic data to immunization registries and actual submission where required and accepted ✓ **Reportable Lab Results:** At least one test of submission of electronic data and actual submission where required and accepted to state or local public health agencies ✓ **Syndromic Surveillance[2] Data:** At least one test of submission of electronic syndromic surveillance data to public health agencies, where possible, and actual transmission according to applicable law and practice **** At least 1 public health objective (Priority Area #4) must be selected as one of the five Menu set measures***

Stage 2: The Stage 2 meaningful use criteria will encourage the use of health information technology (HIT) for continuous quality improvement at the point of care and the exchange of information in the most structured format possible, such as the electronic transmission of orders entered using CPOE and the electronic transmission of diagnostic test results, e.g., blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, pulmonary function tests, and other such data needed to diagnose and treat disease. every objective that is optional for Stage 1 to be required in Stage 2 as well as revaluate the thresholds and exclusions of all the measures both percentage based and those currently a yes/no attestation. Additionally, criteria may be applied to all outpatient hospital settings, not just the emergency department.

Stage 3: The Stage 3 meaningful use criteria will focus on focus on promoting improvements in quality, safety and efficiency leading to improved health outcomes, focusing on decision support for national high priority conditions, patient access to self management tools, access to comprehensive patient data through robust, patient-centered health information exchange and improving population health.

Visit http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf to access the source document.

For information see www.healthinsight.org, or contact *HealthInsight* by phone 1-800-483-0932, fax 877-335-2490 or email rec@healthinsight.org.

[2] http://www.cdc.gov/ncphi/disss/nndss/syndromic.htm

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Adoption of Health Information Technology
Critical Access Hospital Incentives

HealthInsight
a partnership for the future of health care

PAYMENT INCENTIVES
Critical Access Hospitals

Medicare

Critical Access Hospitals (CAH) that adopt a certified EHR system and are meaningful users can begin receiving incentive payments in any year from FY 2011 to FY 2015. However, in no case will a CAH receive an EHR incentive payment for more than four years. Regardless of the payment year, the incentive payment is the **product** of the following:

The **Reasonable Costs:** Reasonable cost is based on any costs incurred for the purchase of a certified EHR system during the cost reporting period and any similarly incurred costs from previous cost reporting periods Reasonable cost includes acquisition costs, excluding any depreciation and interest expenses related to the acquisition, incurred for the purchase of depreciable assets such as computers and associated hardware and software necessary to administer certified EHR technology.

The **Medicare Share** plus 20 percentage points. The Medicare Share is based on the most recent cost reporting period and determined by this formula:

$$\frac{\textit{\# IP Part A Bed Days + \# of Part C Bed Days}}{\textit{Total IP Bed Days X}\left[\dfrac{\textit{Total Charges – Charity Charges}}{\textit{Total Charges}}\right]} + .20$$

Reduction of Reasonable Cost

If the hospital has not demonstrated meaningful use of its EHR by FY 2015, its reimbursement will be reduced from 101 percent to 100.66 percent of reasonable costs. For FY 2016, reimbursement will be reduced to 100.33 percent. For FY 2017 and each subsequent year, reimbursement will be reduced to 100 percent. Hardship exceptions may apply.

Medicaid

Provided the state where the hospital is located is ready and participating in the Medicaid EHR Incentive Program, hospitals that adopt a certified EHR system and are meaningful users can begin receiving incentive payments in any year from FY 2011 to FY 2016.

States may pay hospitals up to 100 percent of an aggregate EHR hospital incentive amount provided over a minimum of a three-year period and a maximum of a six-years. The aggregate EHR incentive amount is the total amount the hospital could receive in Medicaid payments. It is the ***product*** of two factors:

1) The **Overall EHR Amount:** Determined by the ***product*** of the following factors:
   a. The **Initial Amount**: $2,000,000 + [$200 per discharge for the 1,150th – 23,000th discharge].
   b. The **Medicare Share**: Set at one (1) by statute.
   c. The **Transition Factor**:

Transition Factor	
Year 1	1.00
Year 2	0.75
Year 3	0.50
Year 4	0.25

2) The **Medicaid Share** is determined by the formula:

$$\frac{\textit{\# IP Medicaid Bed Days + \# of Medicaid Managed Care Bed Days}}{\textit{Total IP Bed Days X}\left[\dfrac{\textit{Total Charges – Charity Charges}}{\textit{Total Charges}}\right]}$$

There will be no incentive payments after 2021.

OTHER INCENTIVES

1) Eligible hospitals may participate in both the Medicare program and the Medicaid program, assuming they meet each program's eligibility requirements, which vary across the two programs.
2) Low cost loans and grants may be available for purchase of hardware, software, and implementation.
3) Assistance with selection, adoption, and workflow and/or process redesign will be provided by the Health Information Technology Regional Extension Center

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ELIGIBILITY

Medicare

To be eligible for the payment incentives, a hospital must:

1) Use a certified EHR in a *meaningful** manner; and
2) Report on hospital clinical quality measures.

**See definitions below*

Medicaid

To be eligible for the payment incentives, a hospital must:

1) Use a certified EHR in a *meaningful** manner;
2) Report on hospital clinical quality measures;
3) Have at least 10% of patient volume attributable to Medicaid;
4) Have a CCN that has the last four digits in the series 0001 – 0879 or 1300 – 1399; and
5) Have an average length of patient stay of 25 days or fewer.

**See definitions below.*

DEFINITIONS

Meaningful Use of Certified EHR Technology: The eligible hospital *demonstrates* that it is using certified EHR technology in a meaningful manner (see HealthInsight's ***What is Meaningful Use*** document), which includes the use of electronic prescribing.

Demonstration of Meaningful Use
A hospital may satisfy the demonstration requirement through means specified by the Secretary, which *may* include:

1) An attestation
2) The submission of claims with appropriate coding
3) A survey response
4) Reporting on clinical quality measures using an EHR
5) Other means specified by the Secretary

Note: The Secretary may not require the electronic reporting of information on clinical quality measures unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis.

Please refer to source documents for detailed information: http://www.cms.gov/EHRIncentivePrograms

For information see www.healthinsight.org, or contact *HealthInsight* by phone, 1-800-483-0932, fax 877-335-2490 or email rec@healthinsight.org

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TABLE 10: Clinical Quality Measures for Submission by Eligible Hospitals and CAHs for Payment Year 2011-2012[5]

Measure Number Identifier	Measure Title, Description & Measure Steward	Electronic Measure Specifications Information
Emergency Department (ED)-1 NQF 0495	**Title:** Emergency Department Throughput – admitted patients Median time from ED arrival to ED departure for admitted patients **Description:** Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department **Measure Developer:** CMS/Oklahoma Foundation for Medical Quality (OFMQ)	http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage
ED-2 NQF 0497	**Title:** Emergency Department Throughput – admitted patients Admission decision time to ED departure time for admitted patients **Description:** Median time from admit decision time to time of departure from the emergency department of emergency department patients admitted to inpatient status **Measure Developer:** CMS/OFMQ	http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage
Stroke-2 NQF 0435	**Title:** Ischemic stroke – Discharge on anti-thrombotics **Description:** Ischemic stroke patients prescribed antithromboti therapy at hospital discharge **Measure Developer:** The Joint Commission	http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage
Stroke-3 NQF 0436	**Title:** Ischemic stroke – Anticoagulation for A-fib/flutter **Description**: Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge. **Measure Developer:** The Joint Commission	http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage
Stroke-4 NQF 0437	**Title:** Ischemic stroke – Thrombolytic therapy for patients arriving within 2 hours of symptom onset **Description:** Acute ischemic stroke patients who arrive at this hospital within 2 hours of time last known well and for whom IV t-PA was initiated at this hospital within 3 hours of time last known well. **Measure Developer**: The Joint Commission	http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage
Stroke-5 NQF 0438	**Title:** Ischemic or hemorrhagic stroke – Antithrombotic therapy by day 2 **Description:** Ischemic stroke patients administered antithrombotic therapy by the end of hospital day 2. **Measure Developer:** The Joint Commission	http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage

[5] * In the event that new clinical quality measures are not adopted by 2013, the clinical quality measures in this Table would continue to apply.

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